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ABSTRACT

The paper examines the Work Health Organization's (WHO) community based rehabilitation (CBR) scheme currently being field tested in a number of countries and examines also the usefulness of the WHO/CBR manual "Training Disabled People in the Community." The development of alternative CBR schemes in Asia, Africa, and Latin America since the 1960s is outlined. The report cites as arbitrary the demarcation posited between community based rehabilitation and institution based rehabilitation because it excludes the middle ground of rehabilitation based in community-run neighborhood centers. Strengths and weaknesses of the neighborhood center and WHO-style home based rehabilitation are compared, and factors are cited which favor the neighborhood approach. Cost considerations are also examined. An account is offered of mobilizing community resources for neighborhood rehabilitation centers in Pakistan. Recommendations are made for future community rehabilitation plans, with emphasis on the development and dissemination of rehabilitation skills and information through appropriate media. A nine-page reference list and a selection of review comments on the first draft of this paper are appended. (CL)

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WHERE THERE IS NO REHAB PLAN

M. MILES

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WHERE THERE IS NO REHAB PLAN

A critique of the W.H.O. Scheme for Community Based Rehabilitation : With suggestions for future directions.

Summary

This paper examines with extensive documentation the theoretical and practical functioning and flaws of the W.H.O. Community Based Rehabilitation scheme currently being field tested in a number of countries, and of the Manual "Training Disabled People in the Community" The development of alternative C.B.R. schemes in Asia, Africa and Latin America since the 1960s is outlined.

It is demonstrated that the antithesis posited between "Institution Based Rehabilitation" and "Community Based Rehabilitation" is artificial, excluding as it does the middle ground of inexpensive, appropriate rehabilitation based at community run neighbourhood centres. The strengths and weaknesses of neighbourhood centre based rehabilitation and the W.H.O.-style home-based rehabilitation are compared, together with the many social, economic and demographic factors favoring the former approach. Cost considerations are examined in some detail.

An account is given of experience in mobilising community resources for neighbourhood rehabilitation centres in Pakistan. Recommendations are made for future Community Rehabilitation plans, with emphasis on the development and dissemination of rehabilitation skills and information through appropriate media.

PREFACE

The first draft of this paper circulated in August 1984 to about 60 persons actively involved in or concerned with community-directed rehabilitation and having international experience. Reaction was overwhelmingly positive, and there has been a steady demand for further copies. The present edition has been slightly modified for a broader readership. Some review comments from all over the world are appended by permission of the authors, which contributes a great deal to obtaining perspective on the issues discussed herein.

I acknowledge with grateful thanks the comments received from Ann Darnbrough, Fr. Adam Gudalefsky, Virginia Hoel Rafiq Jaffer, Ronald Huckstep, Eloisa de Lorenzo, Jeffrey Miller, Peter Mittler, Ed Sackstein, Evelyn Sithole, Molly Thorburn, David Werner, Don Westaway and Pam Zinkin. I am indebted to Barbara Duncan and Diane Wobds for their advice on editing. I am grateful for the secretarial assistance of Ms Avril Cooper and Mr. John Tarzewell. Finally I would like to record a general appreciation of the many individuals and organisations who have supplied periodicals conference papers and other materials during the past seven years, which enabled me to construct a global picture of rehabilitation progress in developing countries.

October 1985

M. Miles
Peshawar

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A CRITIQUE OF THE W.H.O. SCHEME FOR COMMUNITY BASED REHABILITATION WITH SUGGESTIONS FOR FUTURE DIRECTIONS

1.0 INTRODUCTION

The World Health Organisation claims (1) to have introduced its Community Based Rehabilitation (C.B.R.) scheme in 1976. Ten years later the scheme has achieved some publicity and generated a great deal of activity; but the question of practical results in terms of rehabilitating disabled persons remains moot. In the meantime more than a dozen alternative approaches to C.B.R. have been aired, as outlined below, and much material has been published precisely with a view to disseminating rehabilitation skills to the community at large (2).

Few people have the necessary knowledge and experience, the political freedom, the financial independence, writing ability, time at their disposal and the means to circulate their views, to make it possible for them to formulate an adequate critique of the W.H.O. scheme. I do not consider that what I have written is adequate, but it may suffice to initiate a proper discussion.

Even where the necessary conditions are fulfilled, few people will be sufficiently motivated to spend the time required. Several times I have postponed writing, but finally was goaded by the realisation that an increasing number of dedicated and hard-working volunteers are being persuaded to work in a scheme that has a number of fundamental flaws. There is no surplus of volunteer enthusiasm and energy in the Third World. What exists cannot be permitted to go to waste or to turn sour. There are in fact enough good ideas, alternatives, promising possibilities and accessible field experience in community based rehabilitation to make much better use of the energies of everyone concerned for disabled persons in neglected areas of the Third World. The available knowledge must be disseminated and made accessible to every person who could respond to it.

Since the number of disabled people runs into millions and the vast majority have no public voice or political clout, the development of C.B.R. is too important to be left to the "experts". This paper examines the more outstanding difficulties together with some field experience and suggests directions in which the scheme might usefully develop. Despite the inadequacy of information resources in Peshawar, I have tried to give supporting documentation for as many of my comments as possible.

2.0 THEORETICAL PROBLEMS

2.1 Priorities

The WHO rehabilitation scheme did not respond to a priority request from target communities. A recent WHO document reviewing primary health care development (3) states that "the basic needs of adequate food and land were cited by many countries as priority needs, with 'health' being included only later in the list." Dr. Charles Elliot has pointed out that education, a reliable supply of clean water and better marketing opportunities are usually accorded a far higher priority than health care (4) If this is the case for health care, there can be little doubt that handicap care has even lower priority, affecting as it does a smaller proportion of any community.

The authors of the WHO Manual "Training Disabled People in the Community" (5) misinterpret the evidence when they assert that "Governments are not inclined to believe that disability in the community is a problem..." The evidence from the International Year of Disabled Persons (1981) is that Governments are seldom ignorant of the fact that disability is a problem; but they do not consider it a high priority, and this reflects the feeling of the general population as reported in the literature of at least 30 developing countries surveyed recently (6).

2.2 Statistics

Rather than being a priority request from the target communities, the need has been visualised from Geneva, New York, Stockholm, in terms of a great mass of suffering, marginalised and disabled little people living "out there" in remote areas of the Third World. The magic figure of "10%" has sprung up from somewhere, and has been fixed as the official United Nations figure for the number of disabled persons in the world. Here it is necessary to distinguish between 5 categories of statistics:

(1) Disability estimates, designed to bolster propaganda for increased budgetary allocations;

(2) Disability estimates arrived at by a team of medical and educational specialists intensively examining a random sample of population;

(3) Disability estimates having a purely functional guideline e.g. "if suitable employment were available, could this person perform with an efficiency within one standard deviation of the norm";

(4) Disability as perceived by a given localised population;

(5) Estimates of the number of disabled persons who could benefit from rehabilitation.

The fourth and fifth type of estimates are the most relevant for present consideration. A report from India remarks "one finds that only about 1/7th of those spotted as retarded by the test screening were reported to be so by significant members of the community" (7). A national sample survey of locomotor, visual, hearing and speech disabilities in India discovered 1.8% of the population having these disabilities (8). A lay survey in Venezuela discovered approximately 1% of the population disabled (9). A slightly lower percentage (0.7%) is reported by a paediatrician during his informal but detailed study in Nepal (10). An extensive "key informant" survey in Bangladesh produced a similar result (0.8%) for handicapped children (11), and Robert Serpell (12) gives a figure of 0.5% for "easily identifiable" children with disabilities, based on a Ministry of Education survey in Botswana. Contrasting this with the US Office of Education figure for school-age disability (10.0%) one Third World epidemiologist with fine understatement remarks "There is an apparent gap between the reported prevalence and visibility level of the disabilities" (13). Even a WHO sponsored study in Bacolod, Philippines, trying hard to reach the "universally accepted figure that 10% of any given population is disabled" could discover only 3% in practice (14). Another WHO document (15) estimated that disabled persons who could benefit from rehabilitation amounted to 1.5% of the total population of several developing countries

The pinch comes when these figures are compared with the WHO's reported success rate of 70% using its CBR scheme (1). Out of 1,000 population of village X, the WHO says that 100 (or 10%) are disabled, and that with CBR it can effect some improvement in 70 of them, leaving 30 unimproved. But the villagers perceive only 10 (or 1%) of them are disabled anyway. These 10 are likely to be among the 30 unimproved by the WHO scheme, since they will be the more obviously disabled people who are of course more difficult to rehabilitate. The population of village X are unlikely to be impressed. They did not request CBR in the first place. What they invariably ask for, if they have to have something in the rehabilitation line, is a complete cure preferably carried out by some fancy treatment.

The above quoted WHO figures were based on 576 case reports, and the inadequacy of the criteria for "improvement" have been severely criticised by David Werner in his commentary on Dr. Periquet's CBR monograph (14). It is further highly instructive to see Robin Hindley-Smith's breakdown of 281 disabled persons identified in the Mexico field testing of the WHO scheme (16). He points out that approximately 29% of these

disabled persons "do not need any assistance with their disability to lead a normal life", while 30% need specialist help. The remaining 41% are considered suitable candidates for assistance from community health workers. Analysis by Berman and Sisler (17) of a scheme to rehabilitate blind persons in rural areas of the Philippines showed 54% of the clients receiving modest to major benefits.

2.3 Existing Community Resources

It is fundamental to planning for community welfare services first to find out what exists in the community, and to investigate the possibility that disabled perople may have some alternative sources of treatment. Rehabilitation workers in developing countries usually find a mixture of attitudes towards, and activities for, disabled persons on the part of their families and communities (6). The average family in the Third World quite possibly does more for its disabled members than the average family in the economically advanced countries. In the latter, the mildly and moderately disabled are labelled as such, suffer stigma and are put into the hands of specialists; while the severely disabled tend still to be unloaded into residential dumps. In the Third World, by contrast, the mildly disabled person is seldom labelled or stigmatised; while the severely disabled person is at least given sustenance and shelter by his family, who can much less easily afford to do so than their Western counterparts.

Note in these circumstances the remarkable arrogance of the WHO Manual's statement: "CBR is a new approach. The families are given the responsibility of training their disabled members..." "Given" by whom? Given, by people who have never shared their poverty-stricken means with a disabled relative; to families who have done so without question. Certainly there can be a great deal of prejudice, negative attitudes and harmful practices in Third World families with a disabled member. But there are also plenty of Third World families, both rich and poor, who have made great efforts by themselves for the rehabilitation of their disabled member, without either help or interference from outsiders.

In the early days of primary health care, the mistake was made of ignoring existing indigenous resources. More recently the trend has been to distinguish the useful, the neutral and the harmful practices, encouraging the first, tolerating the second and manoeuvering away from the third. Examples of useful rehabilitation resources: (a) the Eastern custom of massage, both for babies (18) and for the whole family (19), constitutes a widespread therapeutic skill which could be utilised for the benefit of

polio and cerebral palsy affected persons; (b) approximately 2% of the ordinary school population in Pakistan are appreciably disabled and are casually integrated in the normal classrooms without any fuss being made (20) and a rather higher percentage in Botswana (12); (c) the "ceremonial bath" given to some African babies by senior female relatives about 7 days after birth, during which the baby is closely examined and any impairments can be noticed; (d) the Eastern assumption that practically everyone gets married when adult, whether disabled or not (21); (e) absence of Western preoccupation with date of birth, allowing developmentally delayed children to reach school-going capability later than their peers without acquiring the label "retarded"; (f) use of acupuncture in rehabilitation of drug abusers and for some types of hearing impairment; (g) the Kongo proverb (22) "No weak, small or disabled individual is a half person; likewise no strong, big, healthy or wealthy person is two persons."; (h) classroom solidarity in certain countries, whereby if a pupil falls behind the rest then the whole class feels disgraced for its failure to give adequate help to the comrade; (i) practice of yoga with mentally retarded persons (23); (j) the "sensorimotor stimulation traditionally practised by many grandmothers and mothers" in North Africa (24); (k) the positive development-oriented Chinese term "CHI-JR" denoting mental retardation, literally meaning "Opening" or "Revelation" of "Wisdom" or "Understanding"

2.4 Existing CBR Experience

In addition to their failure to appreciate existing Third World community rehabilitation resources, the WHO Manual authors are mistaken in claiming that the WHO scheme is new or innovative. In fact during the 15 years preceding initiation of the WHO scheme there were community orientated rehabilitation schemes being tried in many parts of the world. From 1961 Ronald Huckstep was developing methods of polio treatment and rehabilitation appropriate to the resources of rural Uganda (25). Mahfoud Boucebci reports that "faced with the lack of available places in the few local specialised institutions, and dissatisfied with sending their children abroad, in 1970 parents of handicapped children in Algiers formed an Association and opened a small multi-purpose centre" (24). In India during the 1960s, Dr. S. Ghosh was conducting comparative studies of home-based and institutionalised education of deaf children, and reporting in favour of the former (26), while N.M. Patil was developing appropriate orthopaedic equipment from material available in rural India (27). During the same period, Grace Ingham was training Ghanaian itinerant welfare workers to engage in home rehabilitation with hundreds of blind village women (28).

John Dixon reports from China with reference to the early 1970s that "Chinese families with handicapped members (find) themselves the focus of a network of community-based supportive services including home help and day care which not only shares the burden of care but also inhibits the development within the family of any feelings of social isolation." (29) During the same period, Ms. Sophie Levitt was introducing paediatric physiotherapy in South African villages (30), Robin Hindley-Smith was investigating possibilities for CBR in Latin America (9), Fr. Adam Gudalefsky was helping in rural areas of Nepal to start small community-based rehabilitation centres (31) while Molly Thorburn was training community-based rehabilitation aides in the West Indies (32). In the Cameroons, the Freres Jaccard were developing low cost prosthetics (33) while Sister Cecile Cusson was studying and responding to the needs for community orientated rehabilitation of jungle tribespeople (34). Dorothy Fitchner was developing experience and assembling materials in several African and Asian countries for home rehabilitation of visually impaired children (35), while from 1969 onwards the Portage Project was doing similar work for developmentally delayed persons in the rural USA and more than 20 other countries (36).

These are merely a few of the reported community-orientated rehabilitation activities. Since the majority of rehabilitation practitioners have neither the time nor the energy to write, nor an adequate medium for dissemination of their experience, it may be presumed that a great deal has been going on unreported, since the mid 1960s. The problems have been evident enough for long enough, to several thousand Third World rehabilitation workers who had initially been based in institutional centres serving a small fraction of the need. In some cases, the initiative has gone towards preventive action and the development of appropriate technology (37). For some, appropriate vocational rehabilitation has been the lead-in, as in the development of Horticultural Therapy in Cameroon and Zimbabwe (38), realistic vocational training for the blind in Tamil Nadu (39) and a variety of schemes in Indonesia (40,41). In other cases, mental health in rural communities (42,43) or leprosy management (44) has served to initiate a community based rehabilitation scheme. Nor has this development been confined to the less developed countries. Examples such as the Delaware Curative Workshop, USA (45), and the Eastern Nebraska Community Office of Retardation (46) show that economically powerful nations have from early on been interested in community orientated rehabilitation services.

2.5 The Big, Bad Institution

Since so much community orientated work has been going on, how did the WHO come to imagine that it was presenting an innovative programme? The answer lies in the creation of a false

opposition between so-called "institution-based rehabilitation" and "community-based rehabilitation". The WHO authors never say precisely what they mean by "institution-based rehabilitation", but Dr. Periquet gives some indications: "Institutions require huge capital outlays for the construction of buildings and their maintenance. High cost and sophisticated equipment are necessary. Locally unavailable, this equipment is imported, thus requiring expenditure of foreign exchange. At the same time, it is just as expensive to train the team of highly specialised professionals necessary to deliver rehabilitation services." "It is only through massive doses of financial and technical assistance from developed countries and international donors that the services are visibly increased" (14). Another report states that "such rehabilitation generally requires teams of highly specialised professionals, expensive technology and boarding facilities... Services in general are very expensive and have low through-put " (1)

2.6 The User-Friendly Institution

Some institutions are exactly as described by Dr. Periquet. Yet there exist also some modest sized, inexpensive rehabilitation day-centres with strong community roots, using locally available materials, with local staff having adequate but inexpensive training, providing affordable rehabilitation services to large numbers of disabled persons. These are community-orientated or community-centred facilities responding to a known demand from the community. Some have been set up by local persons interested in having such facilities. This is the policy being pursued by the FAMH/UNICEF Community Rehabilitation Development Project in the North West Frontier Province of Pakistan, having affinities with that described by Boucebci in Algeria (24), and David Werner in Mexico (47). The latter indeed has informed me that "I agree with you completely about the importance of an intermediate level community based rehab center involving committed local people and disabled persons themselves as staff... This is pretty much what we're trying to do in Mexico." (48)

Evidently a similar conclusion was reached in Jordan as described by Lena Saleh (49). "Asked once by a rehabilitation specialist from the USA, who was visiting Jordan, as to what programme or service I considered a model worth replicating, my choice fell upon a small centre for 20 severely retarded children in a community on the outskirts of Amman. Started as a playgroup in an old caravan, recently 2 rooms have been added on to it and the programme is managed by 5 people from the community, one of them the mother of a retarded child. Medical services are provided by the health centre next door, the hot meal comes from the central school feeding centre, and last but not least, the centre

enjoys a good standard of programme and care. The centre premises are also being used in the afternoon to offer physiotherapy services to the community."

Interestingly enough, the above descriptions are practically identical with those used by Dixon and Davies in their useful compilation (50) on the extensive contribution of the US Peace Corps to special education and rehabilitation in many developing countries: "For the purpose of discussion...a community-based programme would use a modest facility or building as a centre, would be staffed primarily by community workers who receive "on the job" training, would deal with disabled persons more as "clients" or "colleagues", would have a small operating budget, and would provide more general services to a greater percentage of the community population. Of course few programmes fall neatly into one category or the other, but rather have elements of both."

One programme having "elements of both", and demonstrating that an institutional base is compatible with a community orientation, is the All India Institute of Speech and Hearing at Mysore. Its buildings are extensive, its staff highly qualified and its stated purpose is "to provide professional training (BSc, MSc) and research facilities in the field of speech and hearing". Yet in pursuing these highly specialised "institutional" goals, the AIISH manages to get its staff and students out into the rural areas to hold speech and hearing camps "treat 600/700 persons daily from en masse screening, with a full service of ENT examinations, audiological tests, hearing aid prescriptions, counselling, psychological testing for learning difficulties, on the spot essentials of speech therapy where appropriate, and subsequent follow-up at the Institute or at other appropriate facilities". (51). The AIISH makes no charge for its public services, and its public education service includes a series of pamphlets, counselling by correspondence and liaison with a large number of local service organisations which assist in the extension activities.

Another "community orientated institution" is the Christian Hospital Taxila, Pakistan, where in the past year 80 staff have received 140,000 patients on a first-come-first-served, no-profit-no-loss basis. Since 1960 a Pakistani and an American surgeon have removed 170,000 cataracts between them in the hospital and eye camps, besides a large amount of other preventive and rehabilitative eye surgery. People willingly journey from 800 miles away to get themselves operated at the small rural town of Taxila, knowing that they will be served without regard to rank or status and that they will be charged the minimum cost of the service. The fact that the staff belong almost entirely to the weakest socio-economic minority in the country may have something to do with this determination to serve the common man.

The question to be examined is: which are the most appropriate methods for mobilising and applying rehabilitation resources for the greatest number of disabled persons? Is it the expensive, big city rehabilitation palace full of foreign equipment and highly trained specialists? Is it the ultra low cost, low-expertise, home rehabilitation scheme tacked onto existing primary health care or community development schemes? Or is it the inexpensive local community rehabilitation centre as previously described? The answer, of course, depends on a large number of factors including the level of development in a country, population structure, local consciousness of disability as a priority problem, and so on. But I anticipate that the modest local centre will account for a growing percentage of actual rehabilitation in the next 20 years.

2.7 Different Needs: Different Answers

To pretend that all developing countries are equally interested and resourceful is incompatible with realistic planning. The primary health care evaluation document previously referred to (3) suggests that "community involvment in PHC never begins effectively in reality prior to communities reaching a certain threshold in economic, social and educational development." The same will undoubtedly apply to rehabilitation efforts, as noted in the Philippines "Reaching the Unreached" report (52).

Lena Saleh points out (49) that "When studying national planning for handicapped individuals it is clear that there is no single pattern of service delivery that can fit all areas. Communities differ in many respects, administrative structure, legislative provisions, population and population distribution, economic and cultural conditions, manpower resources. These variations will lead to the adoption of different models of service delivery. Newly starting countries have the chance and the choice to move towards novel solutions in response to expressed and felt needs."

Population structure alone makes a considerable difference. The WHO/CBR scheme is being field tested in Botswana, Pakistan and St. Lucia among other places. Botswana has a population of one million in 600,000 sq. kms. Its major town has about 60,000 population. St. Lucia has 130,000 population in 600 sq. kms. Pakistan has over 90 million population in 900,000 sq. kms. with more than 40 major cities accommodating 20 million persons. In Pakistan and Botswana the adult literacy rate is about 20% in St. Lucia 80%. The optimal strategies for such disparate countries are unlikely to be identical: one is talking about different problems, different scale. For example, a conference of African nations expressed doubts about the replicability of Botswana's CBR experience, because of its "unusually

small and ethnically homogeneous population, by comparison with other African nations" (53). The lines of communication and the way people are motivated, the sense of community and the Government resources differ from a small island to a large, almost empty country, and differ again from the latter to a large, densely packed nation.

The most fundamental of all questions are : "what are the local people prepared to do for themselves ?" and "Would they achieve more with outside input ?" Here again, the answers differ from country to country, and from region to region of a given country, and from village to village within a small district. The sole answer recurring consistently is that the local people are likely to achieve more if they have participated decisively (not just cosmetically) in formulating the plan and strategy. In fact the paucity of such community participation has been identified by the UNDP as one of the weakest aspects of PHC programmes (54). This insight was basic to the FAMH/UNICEF Community Rehabilitation Development Project which did little more, initially, than to draw together parents and close relatives of disabled children and tell them that if they could think of anything they would like to do for disabled children in their town, we would be prepared to help them do it. What they thought of, uniformly, was a local rehabilitation centre using local resources to provide a practical and affordable level of rehabilitation. They would have liked a big, fancy, rehabilitation palace but they knew it was neither affordable nor sustainable.

3.0 PRACTICAL PROBLEMS

3.1 Evaluation

It was suggested to the WHO more than 3 years ago that "there is a need for thorough evaluation research to take place in the areas in which they (the training Manual packages) were tried, by a researcher who was not involved in the preparation or the implementation of the training Manuals" (55). Additionally, the researcher must be familiar with the country under investigation and with the languages of the target area; and should be financially independent of the outcome of the research. Such evaluation has nowhere been undertaken. A consultation in Colombo concerning the WHO's CBR scheme recommended that a further 3,000 to 4,000 report sheets from field testing should be analysed by WHO (1). This remains to be completed, and in any case is liable to success-orientated bias from both the reporters and analysts. The only really good published independent evaluation of a CBR scheme is that commissioned by

Helen Keller International of their scheme for rehabilitation of the rural blind in the Philippines, which appears to have been entirely independent of the WHO scheme in that country. (17)

The need for complete independence of the evaluators was underlined for me by the remark of one of the participants in the Colombo consultation, whom I had congratulated on his country's report. He said "Actually, we are not using the WHO Manual and we are not doing the scheme their way, but we have to pretend that we are because otherwise they will cut off our support." This remark has been echoed in Pakistan, where it was discovered that deviations, even in the light of experience, were frowned upon. The scheme, in practice, has become a strait-jacket.

This was not the intention of the initiators, but schemes develop a life of their own, especially if political battles have to be waged in order to gain acceptance. The WHO scheme and its proponents are in contrast with most of the alternative types of community orientated rehabilitation schemes in this respect. Among the other schemes there is more interest in exchanging ideas, comparing notes, learning from one another adapting and modifying. The WHO scheme has tended to be self-isolated, seemingly threatened by the range and quality of alternative experience.

3.2 The P.H.C. Link

The WHO scheme suffers from being tied too closely with PHC schemes, at least in the conception of its authors. There will no doubt be countries where primary health care is working well, and where the cadres involved will respond positively to an additional input of information and skills. Reports from Burma, for example, are extremely positive and it appears that CBR is successfully being added to PHC in that country. On a broader scale however the WHO/PHC evaluation (3) indicates what a mess most of these schemes are in. Another WHO publication (56) is full of "what went wrong?" articles evaluating PHC schemes.

The questions tend to be raised 10 or 15 years too late. A good crop of Ph.D.s is being garnered in the mid 1980s from P.H.C. debacles that once flourished in the early 1970s. The degree of political opportunism and cynical manipulation exposed for example in Bruno Jobert's analysis of the Indian community health volunteers scheme (57) promotes speculation as to how much health skullduggery practised in 1984 will be due for exposure in 1999 when "Health for All" has somehow failed to

materialise. In Jobert's thesis, planning decisions emerged like rugby balls from a loose scrum, slightly muddy and rarely where expected, to be propelled forward seemingly at random by the boot of the nearest player. Even where there is no deliberate fudging, Walt and Vaughan point out that an organisation like the W.H.O. is liable to be so politically uncontentious, so general and so comprehensive, as to be non-operational, coupled with a tendency to "oversell" a particular policy, which later may lead to disenchantment or disillusionment (58). Both dangers seem to be present in the CBR scheme.

Some of the more successful community rehabilitation schemes currently running are not using health-trained personnel. In the Philippines, community volunteers are operating an adaptation of the WHO scheme. In India, Anganwadi (Courtyard) workers without health training are the front line (59, 60). In western Mexico, rehabilitated physically impaired people without formal education have become admirable community rehabilitation workers (47). In Nepal, village people with minimal education have successfully run small special education centres (31). In Indonesia, there seems to be a mixture of health volunteers and community development workers implementing a rural community rehabilitation scheme (61). Yet it took much argument to have the following phrase included in the Colombo consultation report: "Governments could also implement CBR as a part of other programmes such as those aimed at community development."

3.3 The WHO/CBR Manual

The WHO made a mistake in attaching the authors' names to the Manual, which inevitably caused a personal, individual element of ownership and identification to pervade the CBR scheme. Certainly there should be full and adequate acknowledgement of the hard work and inspiration of Dr. Helander, Ms. Mendis and the late Ms. Nelson. Yet had the Manual appeared solely under the WHO title, as is often the custom when consultants have been paid to write a book, it would have been a great deal easier to amend or rewrite without any clash of personalities or attributions.

For example, the authors claim that "inadequacy of the technical parts of the training packages, illiteracy or inability to understand the text or drawings were extremely rare as a cause of failure (to rehabilitate a disabled person)". This contrasts sharply with the following reports from field testing:

(a) "Many of the professional special educators with whom I have discussed the WHO

Manual on CBR have expressed grave misgivings about its adequacy. Most feel that it fails to do justice to the complexity and arduousness of working with disabled children and that its effective utilisation requires a community worker to become an expert in too many diverse fields. There can be no doubt that the skills and commitments required for successful special education could not be picked up by a mere reading of the Manual. On the other hand, it seems to me unlikely that the average graduate of a Third World primary school would be equipped to absorb through private study much more detail than what is already included in the family training packages. Indeed, the few trial placements of these booklets I have made in rural Zambia suggest to me that some of them are already too complex." (53)

(b) "Except for certain portions of the WHO training Manual specifically those under the hearing/speech/language disorders training package, the rest were generally found to be useful and could be utilised by the local supervisors and the family members in the application of the rehabilitation technique. However...some packages need to be revised or modified to include more techniques for disabilities identified to be prevalent in the sites, e.g. cerebral palsy, polio, blindness and mental retardation." (14)

(c) "One other thing I detected.is the trainees find the booklet too voluminous:-- hence they would rather practise what they are shown than going into the rigmarole of turning papers to see what exercise is next, so they prefer the audiovisual method of learning." (62)

(d) "The response of children with speech and hearing problems was poor." (63)

(e) "The degree of technical effectiveness of the methods described in the Manual have to be elevated against standard techniques through comparative studies." (64)

(f) "Results with the mentally retarded have been nil." (65)

(g) "The Manual provides too little information on many basic topics, is authoritarian, has an inflexible cookbook approach, takes an exaggeratedly symptom orientated position and abounds in confusing generalisations." (Condensation of an extensive critique by David Werner.) (14)

(h) "The hearing test is inadequate and also the behavioural aspects of mental retardation on which I commented on the second version of the Manual. Many of our parents classified the mentally retarded children as having strange behaviour...We are considering preparing our own booklet on moving disabilities, to contain much greater emphasis on cerebral palsy which is our chief type of childhood physical disability." (66)

3.4 Who will do CBR?

The question of who will do front-line work is extremely important in view of the field report from Botswana (67), Kerala (64), Nigeria (62) and Mexico (63) indicating the danger of overloading the local supervisor. Furthermore, some local supervisors asked why they should do extra duties without receiving additional pay. Whether or not they are paid, there is a danger that the latest directive from the Ministry of Health or the Social Welfare Department will become the current preoccupation to the exclusion or neglect of previous duties. The C.H.W. in addition to doling out pills and advice, and referring difficult cases to hospital, is now expected to interest himself in family planning, malaria eradication, adult literacy, blood donation, breast feeding, poly-immunisation, oral rehydration etc., either doing these things or collaborating with other people who are doing them; and in each case keeping voluminous files and records so that his Government can collect statistics and forward them to Geneva. If any CHW or village uplift worker were in fact even half competent in all these fields, plus now the rehabilitation of the disabled, he would long since have gone to the big city and found well remunerated employment.

The actual caseload seems to have varied from 2 to 6 disabled persons per local supervisor in the various field testing sites, with an average of 3 in the Philippines and up to 5 or 6 in Mexico and Nigeria. In some places, attention was concentrated on disabled children, in whom improvements are more quickly visible than in adults. It is not yet clear how long the local supervisor's attention will be needed on average per disabled person. In the Philippines, part-time community workers seem to have supervised the rehabilitation of an average of approximately 9 disabled persons per year, three at a time. In Mexico the inappropriateness was realised of conducting a survey which discovered a much larger number of disabled persons than could be provided with any help. The method was amended to "gradual identification" in accordance with the number of CHWs available (63). A similar modification has been adopted in the Punjab, Pakistan. This insight does not seem to have penetrated to the WHO CBR Manual, which instructs the local supervisor to conduct a survey to find all the disabled persons in the area.

The practice of the FAMH/UNICEF Community Rehabilitation Development Project is to use a survey form in which the final question reads "It is intended that an Association should be formed of parents of disabled children together with social welfare workers and doctors in this city, in order to take action to secure facilities

for special training for the children. Would your family be interested to join such an Association?" The survey is carried out by College students belonging to the area. Thus the survey is itself an exercise in community mobilisation, leading naturally to the formation of an Association comprising the people with the strongest motivation for getting something done. The action they take is entirely up to them, after they have been through their own processes of discussion and planning. The tendency is to decide to set up a small local day centre, or "neighbourhood centre" as it is pleasantly called by Professor Boucebci (24).

The input of the WHO/CBR scheme tends towards a fragmented result in which each family with a disabled member has the burden thrust back upon itself; whereas the Association-forming approach leads to sharing of resources and mutual counselling. The comparative strength and weaknesses of home-based rehabilitation and community-centred rehabilitation need to be examined closely. In either case, the goal will be for the local community, ablebodied and disabled, to move forward to a point where the identity of individuals is not determined by impairments. This can come about through the convergence of two or three quite different factors: diminution of the actual impairments; adaptation to the impairment so that its disabling consequences decrease; adaptation of the community to remove the social and physical handicap constituted by suffering a disability.

4.0 HOME BASE OR COMMUNITY CENTRE

4.1 Home Tensions

One apparent strength of the home based scheme is that the disabled person begins at home. He or she does not need to go anywhere, which in the case of movement disability is an advantage. At the same time, the fact of being at home is a major weakness from several points of view. Emotional and psychological tensions often build up within the family having an appreciably impaired member (68). There may be some rejection, or its mirror-image, overprotection. The home is not usually an encouraging learning environment. Relatives soon acquire fixed, self-fulfilling estimates of what the disabled person cannot do. The depressing and isolating effect of having a disabled child at home, particularly on the mother, has been observed in many different cultural settings. Notions of "equality of value" seem to be rare in the economically backward parts of the Third World (69, 70), and the absence of normal abilities brings an inevitable lowering of both public and private esteem.

The range of "normal abilities" expected may generally be narrower than that of more complex societies, and social pressures may be such that the family expects to give shelter and sustenance for life to its disabled member; but that does not prevent the disabled person from being weighed and found wanting (71).

4.2 Availability of Trainers

In some parts of the world, most family members go out to work during the day. The Nigerian WHO/CBR team had difficulty finding ablebodied people with time to participate in home training of the disabled persons, and this problem is echoed by reports from St. Lucia (72), Botswana and Zimbabwe (73). The more backward the economy, the more likely that all members of the household will be engaged in agricultural labour, herding animals, carrying fuel and water from far off and other labour intensive activities (74). The approach advocated by David Werner (47) emphasises using these every-day activities as an informal context for rehabilitation:--an opportunity which the more enlightened families have in fact taken from time immemorial.

4.3 Utilisation of Resources

Home-based rehabilitation would seem to be prodigal of resources, if there are for example a dozen disabled persons each receiving training separately in a dozen homes with a dozen helpers or trainers all within half a mile of one another. Two trainers might do as much with the dozen disabled persons, either as a group or consecutively, releasing the other 10 "trainers" for economic productivity. Only in a primitive economy does each family practise every skill for itself. Once there is a recognisable community, specialisation takes place. At the same time, talents among home-based trainers would very probably vary:--some people adapt more easily to working with, and teaching, disabled persons. It makes sense to capitalise on talents, to make broader use of them, which can most economically be carried out in a centre rather than in many homes. One solution to the problem of finding "trainers" and maintaining their motivation has been discovered in Mexico, where Werner reports that some disabled people themselves can become excellent rehabilitation workers, following their own treatment. In that case, which applies more to those with a mobility problem e.g. physical disability or blindness rather than those with communication problems, it makes more sense for them to be stationed in a local centre rather than attempting peripatetic duty.

4.4 Aceess to Homes

There are social systems (e.g. the North West Frontier of Pakistan) where the home is

not accessible to non-related males and where women do not customarily leave their homes. In such places the Catch-22 works thus: a male local supervisor would not be permitted to supervise home rehabilitation; a female local supervisor could do so, but one could not be found whose family would allow her to move from home to home. (Our own CRD Project found one female Pushto-speaking Rehabilitation Development Officer with great difficulty, and even she was severely limited in what social custom allowed her to do; in due course she married into a traditional family and she will not again appear in public for some 20/25 years). In any case, for integration with the community at large, and finding solidarity with other disabled persons and families, the home is the wrong place to start.

4.5 Getting a Break

What are the strengths and weaknesses of a local day centre? Some strengths have already been suggested above. The disabled person has the opportunity to start afresh, away from his family, away from those who "know" that he cannot do this or that. At the Mental Health Centre we frequently show parents what their child can do, and they respond "She never does that at home". To which the question is: Did she ever have any incentive or opportunity to try?

The family gets a break from the disabled person: in the case where women customarily stay at home, and they have a disabled child with some degree of emotional disturbance the child sometimes drives the mother to the verge of breakdown (75). The Mental Health Centre, Peshawar, began as a community psychiatric service and thus uncovered the need for disablement rehabilitation services.

4.6 Solidarity, Identity, Confidence

At a local centre the disabled person has the opportunity to create an identity in solidarity with other disabled persons, provided this is fostered by the centre. It is probably a necessary stage on the way towards normalisation and social role valorisation (76): in the case of the women's movement, black consciousness and other ethnic causes, confidence comes with a separate identity which has to exist before it can voluntarily and confidently be laid aside, as forseen by mature disabled advocates (77).

4.7 Visibility and Impact

The visibility factor of the local day centre should not be underestimated. In-home

rehabilitation schemes are practically invisible, difficult to visit, difficult to raise money for, do not easily retain skilled staff since there is little prestige, salary or community recognition, and contribute no "concentrated impact effect". The latter effect we see from time to time at the Mental Health Centre, Peshawar, where parents visit bringing a mentally retarded or multi-handicapped child from a distance. Although the child will not attend the centre, Mrs. Miles has discovered the value of showing the parents around the special school. For the first time they see 30 or 40 mentally retarded children, some very markedly so, all together in one place, busily engaged in activities, playing, singing, working, quarrelling, living. The teachers and pupils relate to one another in a normal way, without fear, pity or condescension.

On some parents the effect may truly be described as electrifying: "I feel completely different about my child" said one mother after 20 minutes of looking around. It is doubtful whether she could have gained her new perspective by visiting individual retarded children in home rehabilitation. On the general public, the effect, as evidenced by comments received following two films of the Mental Health Centre shown on national TV, is also startling. Viewers found it hard to believe that the films had not been heavily rehearsed: they could find no other way to understand the ordinary and friendly interaction between people whom they fitted into a very "different" category. Needless to say, the films had not been rehearsed at all.

4.8. Travel and Transport

There are some difficulties in the centre-based approach, such as the diversity of disabilities and rehabilitation needs; the question of travel to and from the centre; the provision of a building; and the financing of running costs. Transport costs and difficulties in fact exist also for the home-based scheme, as reported from WHO/CBR field testing in Botswana, Nigeria, Mexico and Pakistan. The difficulty of locating disabled persons is also mentioned, in parts of the world where there are no street maps or house numbers. In villages and small towns, the distances from home to local centre would tend to be fairly short. In individual cases where the mobility problem or cost is too great, a home based approach might be preferred.

4.9 Diversity and Skill Multiplication

So far as the diversity of disabilities is concerned, this too is a problem for both home based and centre based rehabilitation. In the case of the centre, experience and skill will accumulate rapidly and will be reinforced as it is utilised for

successive intakes of disabled clients; whereas skills gained in the home based approach by individual "trainers" are likely to be narrow and to disappear since there is no mechanism for preserving them. In the case of children with disabilities, as pointed out by Rehabilitation International in its report to UNICEF (68), there is a great deal of common ground in terms of understanding and maintaining the normal process of childhood development while additionally giving attention to the specific deficit.

Rehabilitation skills and experience are among the most vital resources missing from the Third World. Any strategy that accumulates, preserves and can transmit such skills has a strong advantage over a strategy where skills are thinly scattered and liable to be dissipated. When we decided at the Mental Health Centre to enlarge a playgroup into a special school and make it a resource and training base, we deliberately took in a very wide range of retarded pupils aged 3 to 20, with four different mother tongues and including hearing and visual deficits, cerebral palsy and some specific learning problems, in order to give our staff and future trainees as broad an experience as possible and thus to increase their confidence. After 5 years, one of the teachers left to set up a day centre 150 miles away, enrolling 35 mentally retarded and deaf children. He has been training 8 members of staff on the job from scratch. He is the sole information and diagnostic resource for developmentally disabled children for 50 miles in every direction. He has the confidence to do it, and he has been formalising his experience by writing a training manual for his trainees. It is difficult to believe that he could have gained his present level of competence and skill multiplication had he worked as a home based trainer or local supervisor.

There is, nevertheless, a difference between the goals a local rehabilitation centre might have for polio-damaged children for example and children with appreciable sensory or learning impairments. We have yet to see a member of staff competently involved both in short-term physiotherapy and fabrication of prosthetics aids, and also in long-term special education. The two types of work have a different rhythm and turnover. Although we run both activities at the Mental Health Centre, the staff are not interchangeable. Some multi-handicapped children attend both sides of the work, but the great majority of the physically disabled children are directed to ordinary schools.

5.0 SOME COST CONSIDERATIONS

5.1 Missing Factors

A major question for every rehabilitation strategy is that of cost. Financial problems were reported by several of the WHO/CBR field testing projects, whether transport costs, referral costs or costs required by local supervisors as salary. The cost benefit analysis by the Manual authors makes only a guess at the cost of WHO/CBR, since a great deal depends on whether trainees and local supervisors work' voluntarily, and how widely the scheme is adopted. Two items of major importance omitted from that analysis are the proportional costs of using the services of specialised institutions, both for referrals and staff training, without which CBR cannot function effectively; and the costs of foregone earnings on the part of family members engaged as "trainers".

The difficulty of discovering family members who will act as trainers suggests that foregone earnings make a large hole in the budgets of individual families. The UNCSDHA Expert Group on "Socio-Economic Implications of Investments in Rehabilitation of the Disabled", meeting in 1977, specificially recommended that studies should be made in a number of developing countries of the effects of disability and rehabilitation services on the economic and emotional conditions in the families of the disabled, particularly with regard to the productivity of the non-disabled family members (78). The studies are still needed.

A more general criticism of missing factors in the WHO/CBR cost analysis is made by J.K. Thompson following his extensive I.Y.D.P. tour for the Commonwealth Secretariat: "Discussions in many countries suggest that (CBR) may be embraced for the wrong reason: a saving of money. It is being assumed that great savings can be made on expenditure on institutions. The cost of training the very large numbers of village-level workers--community aides or whatever they are called--is not so far being taken into account. These essential people need not only training but also supervision; and it is the middle-level supervision that, in my view, is going to present the greatest difficulty, as well as costing a lot of money. Moreover, top-level professionals in rehabilitation and therapy will still be necessary and very few of the smaller countries have anything like the full team. We have not yet reached the stage when we can make reliable estimates of the cost of switching from institutionalisation to care within the community. It is a great mistake to assume

that it will cost less than the present meagre grants to institutions. It is an even greater mistake to plan on the assumption that institutions can be done away with altogether. A middle path will have to be found." (79)

5.2. Cost to Whom?

The question is not merely one of cost but of cost to whom. In Pakistan much rehabilitation work is funded by local charities: donations from wealthy local people and Government grants are administered by voluntary workers. In theory the costs of all this private giving of time and money should go down on the bill. But in practice it must be noted that this time and money is given willingly to certain sorts of rehabilitation facility, but not to others. At the local level, one can have certain types of services (sometimes the type now condemned in the West as expensive and inefficient) without financial problems, because the wealthy willingly endow such facilities. It is virtually impossible to prevent them doing so, even it if were advisable, though their action may absorb many of the scarce rehabilitation professionals.

The amounts of money involved are trifling on the national-economy scale, and in many cases are diverted from no very useful purpose. Likewise the t given by the wealthy to organise and administer this type of thing, and to appear prominently on public occasions as noble benefactors of the people, would not otherwise be used to much public benefit. Other sorts of rehabilitation strategy, like the WHO/CBR scheme, are unlikely to tap such sources since there will be no visible philanthropic status attached.

A further peculiarity of health expenditure not always noticed by central planners is that the inexpensive and effective remedy is not necessarily desired by ordinary families with very modest means. Peshawar enjoys the best Paediatrics Department among the medical colleges of Pakistan, and we sometimes refer clients to one of the paediatricians, for example where epilepsy is concerned. On a number of occasions we have been told by families, "Oh no, we went to see him but he is not a good doctor. He wrote down only one cheap medicine. We have been to other doctors who gave us much longer lists full of very powerful (= expensive) medicines."

In our own fees policy at the Mental Health Centre we tend to be very lenient, allowing families to set their own level of fees and only occasionally questioning when the family appears well-to-do but offers little. When one such family failed to make a modest payment and were reminded to do so, they pointed out that in addition to paying our school fees

at the rate of 5 dollars per month, they were paying 80 dollars per session for acupuncture for their severely retarded child. They evidently had much higher hopes from the acupuncturist who was fleecing them than from our underpriced rehabilitation efforts.

5.3 Actual Expenditure and Resources

No developing country knows how much is actually spent on health care among its people, for two reasons: (a) the amount officially expended by the Government is usually an overestimate, since a proportion invariably gets diverted or misapplied; (b) there is no way of measuring the amount spent by individuals on locally produced medicines and healers:--the latter do not of course produce income tax returns. Additionally, time and service given voluntarily cannot be counted as costs in the same category as regular salaries or bricks and mortar, if the input would not otherwise have been used in productive employment.

Foreign consultants examining the economic data of a country sometimes claim that "less than one dollar per head is being spent on health", or some such slogan; and proceed to develop strategy on the basis of this top-down calculation, which is removed from reality. For the rehabilitation centres set up so far in the North West Frontier by NGOs, no money had been budgetted. From calculations of gross national product, per capita needs and income one could estimate that nothing was available. Some local people decided that they wanted to spend time and money in order to have a rehabilitation centre, and they found the time and the money. We advised them to start: get something going in however small a way, so that some disabled people were visibly being rehabilitated. Once there was action, as opposed to mere talk, they would find that money would be donated or could be raised by various means.

For the past few years, aid agencies have been hunting for suitable disability projects to fund. During the entire IYDP (1981), UNICEF found itself unable to spend a single dollar on disability in Pakistan for lack of programmes and skills. I therefore drew up the FAMH/UNICEF Community Rehabilitation Development Project in consultation with local advisers and Provincial Government, to formalise the mobilisation work we had been doing privately and to train local counterparts with this experience. The UNHCR in Peshawar, faced with thousands of disabled refugees, is desperately seeking programmes for them and is prevented largely by red tape and the absence of skills. The National Council of Social Welfare had been badgering me to "do some research on disabled children" and when finally I put in a project proposal they sent twice the amount I asked for, in the hope

that I would do twice the number of studies. The Government of Pakistan in its present five year plan has budgetted 65 million dollars for special education and rehabilitation (which works out at 15 cents per person per year) (80). Nobody seriously believes that they will succeed in spending this amount, for lack of programmes and skills.

When we sent out our Rehabilitation Development Officers, we told them "The local people know, or can find out, what is available in their town: where are the disabled children, what accommodation could be used, who the local philanthropists are, what sort of person they would like to choose to work with their disabled children, which local craftsmen would make equipment if given a pattern to follow, etc. Advise them to start, in however small a way, even if it is under a tree in somebody's courtyard or in a spare room of a house, in the community hall, in the school building after school hours." In practice all these possibilities have been utilised.

At the other end of the scale, three organisations that we helped to start have acquired large grants of public funds to put up prestige buildings. One of them has erected its building, and does not have activities enough to fill it; another already has more outgoing plans than will fit into one building, once they have built it.

Recently I had urgent requests from men in 3 towns. In town A, population 30,000, a local landlord and small factory owner with a 6 year old cerebral palsied son wanted us to go and visit him. We explained that there were over 200 children on our waiting list for physiotherapy. The man then committed himself to provide basic accommodation for rehabilitation work in his town, and to mobilise a local committee which would send us a trainee. In essence this is a redistribution of existing resources, in favour of disabled people, resulting for our refusal to give priority to a high individual bidder. In town B, population 20,000, the municipal committee decided to use its community centre for rehabilitation work. (An influential member of the Committee has disabled nephews.) They anticipate no difficulty finding local resources for running costs. They have sent two people to us for training, one in physiotherapy, one in special education. In town C, population 30,000, the medical superintendent of a mission hospital has decided to start some rehabilitation work and wishes us to train 2 or 3 people. He foresees no problem in getting 50,000 dollars from overseas to put up a building, provided he runs a pilot scheme in existing buildings for a year.

These proposals and activities are not easy to predict, and do not fit comfortably within

Government-style planning or WHO health economics. They are also largely derived from cities and small towns. No doubt the economic picture and available resources of some countries is different, especially those with small scattered populations, huge area and poor communications. But our policy has been to start with the easier objectives and realisable targets for Pakistan and Asia, before tackling the improbable or the impossible.

Our neighbours, India and China, are economically on a level with Pakistan and the 3 countries together have a population approaching 2 billion, more than half of the Third World (81). Although the surface area of these countries is vast, large areas of each are marginally habitable, so that for example some 700 million Chinese occupy a space roughly equivalent to that of Zaire or Algeria which have respectively 30 million and 20 million population. Consequently, although the populations are designated as predominantly "rural", this by no means indicates that the bulk of the population lives in remote or inaccessible or small villages. The UN definition of "urban" as applying to agglomerated settlements of over 20,000 population may be misleading in this respect (82), especially since local population statistics are subject to manipulation: governments sometimes deny urban status to a town in order to avoid having to increase civil servants' salaries.

A "rural" market town may have a poulation of 18,000 and be ringed at an average 4 miles distance by 6 villages with aggregated population of 40,000 and scattered population of a further 20,000. For purposes of planning rehabilitation facilities, the salient point is that there are some 80,000 people within 5 miles of a central point. If a small rehabilitation centre is established near that central point it will soon be known to the people who are motivated to know, whether or not they live in the town. They can then find out where it is, ask questions or visit to discover whether they could get any help. By contrast, if a home-based rehabilitation programme starts in one village or even in the town, it is quite possible that people in the surrounding area may not hear of it; or if they hear they may not be able to locate it. Innovations tend to start in the town and travel from the town outwards; they are less likely to start in the village or to travel from village to village, because that is not how the communication lines run.

5.4 Short Term Residence

An example of community collaboration that can eliminate a major cost of rehabilitation or skill dissemination is in the free or token-cost provision of short term residence by local families in their own homes. The tradition of doing so goes back at least to the 5th century A.D. in the town of Gheel, Belgium, where mentally ill people were received

in ordinary households (83). Modern examples are western Mexico where villagers enable physically disabled children and family members from distant parts to stay in their homes during the period of treatment (47); and Tanzania where, in a settlement plan for older, homeless disabled people, villagers first provided temporary accommodation in disused huts and then gave free labour to build new houses for the disabled people (84). In Indonesia, weekday residence has been provided in local households for disabled adults receiving workshop training, thus avoiding the cost and segregation of separate hostel provision (85) In Peshawar, as the number of staff trainees from outstations has increased, some have been accommodated in the Centre buildings while others have resided for a few months in the houses of permanent staff members.

This is the sort of invaluable and integrative contribution that can arise only when a local community feels genuinely involved in a rehabilitation project. It cannot be demanded by Government (except in time of war or by a totalitarian regime). It is unlikely to arise at all in a Government-sponsored scheme, but can be arranged where a sensitive NGO has prepared the way. In this sense, it is not "replicable" and may therefore tend to be omitted from central planning. To do so is a mistake. Governments should learn to program "areas of community opportunity" into their plans, thus: "If we make a modest beginning with full community participation, the following resources might be made available locally...". This will be difficult for most Governments: it will require a taste of reality and a touch of humility in their plans.

A Government Education officer in the Sind province of Pakistan demonstrated the possibilities for community involvement when he began an experimental mainstreaming project, adding 22 handicapped children to a school with 100 able-bodied pupils. Aware that the 5 titled teachers could not give sufficient time and attention to make the scheme work, the officer appealed to the local community: over 100 educated or technically skilled volunteers now give 1 or 2 hours per week on a carefully organized rota scheme. The effect of this sort of community involvement, which does not appear in the education budget, goes far beyond the immediate benefit to that school, in terms of revised attitudes towards handicapped children and their education.

6.0 EXPERIENCE IN THE NORTH WEST FRONTIER OF PAKISTAN

The grounds of experience on which we base our criticism of the WHO/CBR scheme and make suggestions for its improvement are that for more than 7 years we have been engaged in mobilising communities for rehabilitation work and providing them with the skills and

resources to begin. In justification of the preceding part of this paper I will outline these activities, which now in fact involve more than 100 people including ourselves. What has been achieved in the North West Frontier Province of Pakistan can be done elsewhere; indeed much more can be achieved than we have done.

6.1 Strategy for Multiplication

Large scale rehabilitation for disabled people depends on three factors: motivation, information and application. Motivation already exists in many disabled person and their families who make considerable efforts towards overcoming disability. Information, both for rehabilitation and community awareness, is missing in most developing countries. Yet the means exist in modern communications technology to acquire and disseminate appropriate information very widely. Application means the provision of a context in which well motivated people, receiving appropriate information, act upon it usefully. This section outlines a successful strategy for generating good motivation, providing appropriate information and skills, and mobilising action for and by disabled people.

Arriving in Peshawar in April 1978 as volunteers with the Church of Pakistan, to run a playgroup for mentally retarded children, my wife and I found 3 Pakistani staff and 8 pupils in rented rooms, and a small Frontier Association for the Mentally Handicapped (FAMH). Merely maintaining his playgroup, even if enlarged, would have achieved little. We needed a strategy for rehabilitating thousands of disabled children. (86) The plan initially was to develop a full-time special school, taking on trainee staff who would later be established in new centres where they would train their own staff, and so multiply the system. The new day-centres were to be managed by autonomous local associations of parents and professionals.

In 1978, ours was the sole centre in the Province for mentally retarded and multi-handicapped children. Since then, in accordance with the plan, six neighbourhood centres for mentally retarded pupils have opened, two in Peshawar, one each at Mansehra, Mardan, Wah Cantt. and Karak. Staff for these centres had their initial training from Mrs. Miles and her senior teachers, one of whom in fact started the Mansehra school with his own trainees.

Rehabilitation of several hundred physically disabled children has taken place at the Mental Health Centre since 1980 by training family members at the Centre to give massage, wax treatment and exercises; the disabled child returns frequently for examination and guidance. A low cost caliper workshop began in 1981, with capital outlay of 1,000 dollars.

Family members who are handy with tools sometimes participate in making calipers. The same extension strategy was followed. Staff have been trained and new centres opened at Mingora, Badaber, Karak; physiotherapy has been added to existing work in Mardan, while trainees from Kohat are under instruction. Most of these towns are district headquaters with a population of over 50,000. They previously had no rehabilitation work.

The resource base, i.e. the Mental Health Centre, has an annual budget of 40,000 dollars including 20 local and expatriate salaries, equivalent rent for premises etc. Half of this comes from overseas charities. The new neighbourhood centres have much smaller budgets, and almost all are financed from local charitable donations. UNICEF provided 50,000 dollars over three years plus use of a vehicle, to fund 2 Rehabilitation Development Officers and some translation and vocational rehabilitation work in the PAMH/UNICEF Community Rehabilitation Development Project based at the Mental Health Centre.

Suitable information has been prepared in Urdu: illustrated pamphlets of advice about mentally retarded children; child development observation and skills checklists; special teachers' manuals; physiotherapy aides' manual; vocational rehabilitation manual; advice manual for parents of blind children. General public attitude-formation efforts include two TV films shown nationwide, press items, lectures and contacts with a wide variety of educational institutions and welfare organisations, both in Peshawar and other parts of Pakistan.

The Mental Health Centre conducted studies for the Government of Pakistan, on Attitudes Towards Disabled Persons and on Integrated Education. The latter involved 60 schools in 3 major cities, the formation of a Society for Integrated Education of Handicapped Children and the opportunity to give lectures at Government In-service Teacher Training Courses. A series of radio broadcasts began transmission in the autumn 1984 aimed at rural rehabilitation. (The scripts have already been adapted and used in Africa in French and Swahili). (87)

6.2 Community Mobilisation

The first centre to be mobilised directly through the efforts of the Community Rehabilitation Development Project took off with remarkable speed. At Mingora, 100 miles north of Peshawar and district headquaters of the valley of Swat, 150 families with handicapped children had been identified by college students conducting a survey organized 2 years earlier by the Mental Health Centre for the Government Education Department (86). Those

families were sent a duplicated circular letter inviting them to attend a public meeting. 30 letters were returned as having insufficient address. Yet on the appointed day no less than 75 men arrived for the meeting. One of the Rehabilitation Development Officers addressed these men and pointed out that they all had something in common: a disabled child. Whatever their differences, the common experience among them was sufficient basis for action, and they themselves were capable of taking action jointly to help their disabled children. Nothing more than this was needed to mobilise the men. They elected a Committee. One man gave the use of a house for 12 months; another man promised a regular monthly payment; a father stated that his son had completed his education and would commence straight away to work with handicapped children. This local centre opened within one week. Committee members took part on a rota basis. Money was donated for equipment. The young man whose father had volunteered his services came to Peshawar and received several months training and has returned to Swat and is hard at work.

Another very encouraging start was made without any effort on our part when a retired Army sergeant brought his polio crippled son from a village 7 miles from Peshawar. After 3 months daily treatment (much of it given by the father, once he had learnt the exercises and massage) the boy could walk adequately and was discharged. The father then said, "There are dozens of disabled children in my village. Let me attend for a month's full-time training, then I will set up a treatment centre in my home." We asked him to collect disabled children on a given day, and we would come and inspect them. The man visited only half of his village then stopped: he had already collected 50 children. He directed them to meet at the village school, where we examined them and agreed that he should come for further training. The local Rotary Club supplied equipment for him worth 400 dollars. He is now daily treating physically disabled children in his two-room village home. Those whom he cannot manage, he refers to Peshawar. He charges fees in advance, sufficient to cover materials and also to maintain motivation in families who might not otherwise complete the treatment. Once they have paid him a substantial sum, they keep coming until they have got their full money's worth.

The scheme has not depended on highly trained specialists. Mrs. Miles is a Maths graduate with one year's rehabilitation training as a special teacher. My own previous field of studies was theology. We have been assisted intermittently by expatriates with teaching diplomas and speech therapy training. The only fully qualified member of staff is our second physiotherapist, who has three years training in Karachi. (The first physiotherapist was lured away with an offer of 4 times his salary, by a refugee Aid Agency).

6.3 By the People, For the People

Rehabilitative treatment is now being given to several hundred disabled children daily, by local people, in their own towns, funded locally, using local materials, in their own languages, in accordance with their own customs, with the support of their local communities. I believe it qualifies as community-centred rehabilitation by any definition. Some of it takes place in the homes of the disabled individuals. Several local centres are in rented buildings, some in rooms donated by a wealthier family with a disabled child; two are in hospital wings.

In the towns there are more realistic grounds for hope than in the villages. Our input has fortuitously been well timed: The International Year of the Child (1979) gave a boost, followed by the IYDP (1981), while the President of Pakistan has taken a special interest in this field as the father of a hearing impaired child. Those families have grasped at the opportunity, who felt that it was a priority for them. We calculated that the most strongly motivated key people would be men of professional standing with disabled sons aged between 5 and 15. To ensure that we find and mobilise 2 or 3 such men, we targeted initially towns with more than 50,000 population. Now, in fact, we are being approached by such men from smaller towns. The price of our helping them as individuals is that they cooperate in mobilising their community. Most of them accept the challenge.

In 1966/67 I worked as a college physical education instructor in a West African country of similar size and shape to the present settled and populated parts of the North West Frontier, but with a fifth of the population density: Togo at that time had about 2 million population in an area 650 kms. long and 85 kms. wide. There were very few rehabilitation facilities. Gilbert, one of the senior students at the college, had a deformed foot following polio and limped about using a pole. He was well liked and respected on account of his sober and kindly demeanour. Various efforts were being made by NGOs to promote integrated education. By 1970 there was a Disabled Persons Association running its own small, sheltered workshop, and subsequently several special schools and vocational workshops were opened by Government and NGOs. Given the population shape and communications problems of Togo, it might have seemed a better candidate for home-based CBR than the more densely populated North West Frontier of Pakistan. Yet in fact it now has a good number of small centres, not by any means confined to the cities. Since my time there the Sahel drought has set in, and the northern half of Togo is badly affected. The local rehabilitation centres carry on with their work. But with people uprooting from their homes in search of food and water, it is difficult to imagine how any home-based rehabilitation programme could survive.

Some "experts" argue that prevention of disability must have priority, otherwise rehabilitation demands will always outstrip supply. This parallels the mistaken belief that contraception propaganda is the best way to contain the population explosion. After some 20 years of plausible propaganda, it has become apparent that population growth decelerates as quality of life increases. Family planning then gains credibility. The same probably applies to rehabilitation and the prevention of disability. When the quality of life is enhanced for existing disabled children, the target public will more readily receive the message about "quality control" of future babies.

6.4 Not Forgetting the Villages

What about the remoter villages and the disabled people in them? When I asked myself that question 5 years ago I reckoned that the better motivated families would seek help at the rehabilitation centres in district headquarters which we were then planning to mobilise. Families would take some of the WHO/CBR type of material back to their village and use it, revisiting the centre periodically. This has in fact already been modelled by the Mental Health Centre, where senior staff see families from as far as 500 miles away, counsel them, provide ideas to work on and suggest that they call again when next they can.

Radio has for some time linked the remotest Asian villages with the modern world. Television is becoming established, though already rivalled by the VCR which gives the user an escape from Government propaganda. These media are exploitable for rehabilitation information. We are beginning to broadcast basic rehabilitation advice by radio. Next we will invite listeners to write in, or to visit the rehabilitation centre in their district headquarters. Over the next 5 years we hope to develop more detailed self-instruction Manuals backed by a range of modern audio-visual communications methods plus some oldfashioned ones like glove puppet shows and street theatre.

Demands are placed on disabled persons themselves and their families by these self-help methods. But many disabled persons and their families already make great efforts: they travel from shrine to shrine; they go from doctor to doctor; they ingest potions of lizards' blood chalk and sugar. Every disabled pers n who benefits from the materials offered will become a potential evangelist for the other disabled persons in his area. When some rehabilitated disabled persons get together, there is no telling what they may achieve by way of changing attitudes in their community, creating work opportunities and spreading information. The dedication and tenacity of the ex-disabled person is a major resource for the future.

These activities have been visited by representatives of the WHO, UNICEF, ILO, UNCSDHA, the United States National Institute of Handicapped Research and the Government of Pakistan, who have expressed their interest and appreciation; I believe that they did not do so entirely out of politeness. Mr. Rafiq Jaffer, Coordinator of the WHO/Community Based Rehabilitation scheme field testing in the Punjab, visited us and subsequently wrote:

> "I can say with sincerity that it was a learning experience for all of us, one which will have its impact on the development of rehabilitation programmes for the disabled in the Punjab. You and your colleagues are not only doing pioneering work in the rehab field, but you have set up a model for community rehab which works in Pakistan. And there are not many success stories in community work in this country."

7.0 FUTURE DIRECTIONS

> "Its origins go back, in part, to a day in 1974 when the PAHO Regional Advisor on Rehabilitation and his Venezuelan counterpart left Caracas by car headed for a remote village with the vague idea of seeing what might be done for the disabled there. The Venezuelan turned to his companion and said, "Has either of us any idea of just what it is that we are going to do?" The answer, of course, had to be "No"." (63)

7.1 Introduction

During the 11 years since Robin Hindley-Smith replied "No", many ideas have surfaced for "what to do" to assist disabled people in villages and slums of the Third World. Common to all practitioners of community-centred rehabilitation in developing countries is the "statistical imperative": available skills within existing structures rehabilitate only a small percentage of the disabled people, and feasible arithmetic increase within present structures will make little impact. The disabled population is growing, for many reasons enumerated by the UNCSDHA (88). New approaches must generate an exponential increase in appropriate skills, distributed to where the needs are.

That implies tapping hitherto under-utilised resources within the community. The people currently possessing rehabilitation skills and information need to evolve catalytic and training roles, from the treatment/dependence role that is all too common. In Peshawar, we could have provided a lovely rehabilitation service. individual by individual; we could have had a lot of fun doing it, and earned the undying gratitude of a few hundred families. We aimed instead to mobilise hundreds who in the course of time will inform and train thousands who will affect several hundred thousands. Our rehabilitation service has lower standards and less diversity and less technology as a result of our priorities for resource

allocation. That is a necessary price, in a closed system with limited resources. It is not a question of whether we feel good about it. The Mother Theresas of the world are necessary as sources of inspiration and love, but I believe that the people whom they inspire need helpful frameworks in which to serve, otherwise the majority will find their efforts go to waste.

A number of different structures and possibilities have already been described, to carry the "exponential increase, distribution and application of skills and information". The WHO/CBR scheme is one structure, and it is being applied in a number of ways in different countries. The WHO scheme has developed and improved during the past 5 years, but it still has a long way to go before it fulfils its claims. This concluding section of the critique contains recommendations which could assist the development of the WHO/CBR scheme and which also have some relevance to other CBR schemes.

7.2 Recommendations: Theory

Realistic goal planning is the most important, and perhaps the most difficult, future direction to take: without realistic goals, efforts will be wasted or counterproductive. Difficult, because it involves prediction in a rapidly changing world of diversity, and requires budget prioritisation which may take resources from some people and give them to others, involving ethical, political and philosophical considerations on which individuals and societies may differ radically. This being so, it is all the more important to state basic assumptions and presuppositions, and periodically to check whether the underpinning still holds and is still relevant.

A corollary of realism is diversity. Within the broad framework of multiplying skills, services and self-help, there is room for many approaches, some complementary within one area, some mutually exclusive in terms of affordability. A major criticism of the WHO/CBR scheme is that it has offered a single strategy for all the developing world. One blanket strategy is too few for the diversity of social structures. If the WHO/CBR scheme is to develop usefully, it must broaden its approaches, be more ready to cooperate with existing structures, develop a capacity for "bottom-up" and "hands-across" development in place of its present "top-down" orientation.

To achieve realism, plans need to be both adaptable and target-specific, and to adopt information from many sources. Macro-scale, long-term country planning should look realistically at the nature of society, how people live, their aspirations, what motivates

them, and likely changes in practice during the next 20 years. The same questions need to be asked in much smaller target localities where the answers may in some respects be different. Between the two sets of answers, the questions need considering: what will be the life of people with various sorts of disability in this community in the next 20 years? Does this community want to do anything about it? (89) Then the precise plan will follow from a realistic estimate of the situation, namely: which available resources may be mobilised, where, how, by whom, towards what goals, and why?

Strategies need not only to be intelligent and adoptable by local communities, they must be politically and psychologically marketable. J.K. Thompson points out (79) that Governments are not in practice going to pay now to save later on hypothetical rehabilitation services. Nor, in Third World practice, will they want to look ahead and imagine where disabled people will be in 20 years. The WHO must assist Governments to do so. It requires help from the world's futurologists as well as to spend more time discovering what Third World local communities would like to do. The logic of the WHO Community Based Scheme, applied more widely, would suggest that if for example education were a high priority in community with small resources then they should seek a "Local Education Supervisor" who would recruit family members to educate their children at home. This is an interesting idea, but in actual practice communities are going to continue building neighbourhood education centres known as "schools" for their children!

The WHO advisors may not have realised that the most plausible strategy for the widespread adoption of CBR is the well-tried and inexpensive method of removing the signboard outside an institution and replacing it with a new, freshly painted board proclaiming "Modern Integrated Community-Based Rehabilitation Service:--WHO-approved". In fact, at one CBR seminar under WHO auspices the participants visited several excellent institutions, seeing a doctor working at a primary health clinic, a kindergarten having some disabled children, and a special school for mentally retarded children. Being informed that this was all Community Based Rehabilitation, they applauded warmly. Strangely enough, the seminar papers studiously avoid mention of these types of community centres as examples of CBR.

The World Programme of Action concerning Disabled Persons (90), adopted by the UN in December 1982, is more readable than many UN documents and quite sensibly conceived within the conventional wisdom of its time. Like all UN resolutions, it belongs in the Department of Pious Wishes; but it is sufficiently community-orientated as to sustain the hope that many ordinary people around the world may bypass Government procrastination and bureaucracy

and begin the tasks recommended. The Programme points out (para. 17) that important resources lie in families of disabled people and in their communities and that plans should take into account their customs and structures and should promote their strengths. In what follows, I shall not repeat or condense the programme, which is obtainable from UNCSDHA, Vienna or ECOSOC New York.

One important error in the Programme directly concerns the evaluation of CBR: the assertion that "as many as 80% of all disabled persons live in isolated rural areas in the developing countries". This is seriously misleading. Population density maps show that while most of the surface area of the Third World is thinly populated, the greater percentage of Third World people live in quite densely populated rural areas or cities in a comparatively small number of regions of the world (91,92). Latin America and Africa account for roughly 1,000 population, in 50 million sq. kms., i.e. an average of 20 persons per sq. km., while India, Pakistan and China have 1,900 million people in 13.5 million sq. kms. at an average of 140 persons per sq. km. (81,93). But in fact, making allowance for very sparsely populated mountains and deserts in Asia, approximately 1,500 million people occupy about 6.0 million sq. kms. at an average of 250 persons per sq. km. At this density there will be an average of 2,000 people within 20 minutes walk of any given point In average small towns one can expect at least 5,000 people within 5 minutes walk of a central point (94,95). The majority of disabled persons in this world live in these sorts of population densities, which should be reflected in rehabilitation strategies.

7.3 Recommendations: Practical

The following points arise from the preceding discussion of the WHO/CBR scheme and they should be taken in the context of that discussion.

A) Neighbourhood Centres

Promotion of "neighbourhood centres", to be run by local welfare societies with major representation of disabled persons and their families, should be undertaken by the WHO/CBR scheme as a possible alternative or corollary to home-based rehabilitation, in areas where the population structure and stage of community development is conducive to its success, or where that is what the local community desires and is prepared to work for. Such centres should be part of a continuum of services, open-ended both towards family participation and towards integration of some clients into existing services such as normal schools or vocational training. They should have as one objective to become resource and training bases, and public fountains of skills and information on rehabilitation.

B) Information System

Information flow and skills dissemination should be planned on several levels and with appropriate media; and where necessary with a due amount of pressure. The entire rehabilitation enterprise can be seen as an information system, and to do so is a healthy antidote to the "all-you-need-is-love" school with its tendency towards paternalism and dependency enhancement. Adequate information allows the caring response to take effect in the most fruitful (and therefore ultimately the most loving) manner. Information methods and materials need to be developed and revised and tested for use:

i) Within the neighbourhood centre or home-based system, for direct rehabilitation of disabled persons; for inservice staff training; for family counselling.

ii) Within the local community, for attitude change of opinion leaders and pivotal groups; for participation by local services, e.g. schools, health centre, welfare organisation, in the rehabilitation process.

iii) For a broader public, and for exchange with other developing community rehabilitation systems.

iv) For intensive staff training, conducted centrally; and for other types of centrally run workshop, e.g. for leaders of disabled people's organisations, for the mass media etc.

v) For obtaining and utilising feedback, and for cross-fertilisation between different levels and types of information.

vi) On technical aids and equipment.

These categories need further detailed consideration. The first category is one that the WHO/CBR Manual intends partially to cover, i.e. information for home based rehabilitation. Its flaws and inadequacies result partly from having been written by people who were not actually doing what they were recommending, i.e. rehabilitating disabled children in rural homes or centres; and partly from tackling too broad a field in insufficient depth. The training packages seem to have been conceived as "rehabilitation's answer to "Where There is No Doctor"" (96). But David Werner, before compiling W.T.I.N.D. and before sending it around the world, took the precaution of spending a number of years discovering how to do it, with local people in the mountains of Mexico, and testing it all in practice. There already exist rehabilitation manuals covering in detail most of the major disabilities, written by field practitioners in the developing countries on the basis of extended experience and directed to the same goal of demystifying the procedures of rehabilitation and making them accessible to people without specialised training or lengthy education.

The existence of such materials is not sufficiently known. Indeed when the WHO authors

began writing their Manual, some of the more detailed material had not been published. In the field of learning difficulties, mental retardation and developmental delay, the Portage Project materials (97) had already been adapted and field tested in more than 20 countries by 1981, including areas as undeveloped as the mountains of Peru, and using community workers with elementary education (32). Materials from the Hester Adrian Centre's 'Parent Involvement Project' (98) and from the British Institute of Mental Handicap (99,100) are being field tested in several Asian countries following a skills workshop in Hong Kong (101), while programs associated with the Chapel Hill 'Learning Assessment Profile' (LAP) (102) have been used for several years in rural towns of Egypt (103). For the physically disabled, Huckstep's manual (104) is a classic, while the Hesperian Foundation's formidable compendium (105) is in its experimental stages and will be available in 1986. Once printed, the latter will probably knock everything else out of the market, although this is far from David Werner's intention. Further B.I.M.H. pamphlets (106,107,108) for cerebral palsied children are being translated and tested in several Asian countries. For the blind, Fichtner's "How to Raise a Blind Child" (35) is seminal. Our Urdu translation of it was published recently. For the mentally disordered, Wig and Murthy's manual (109) has been tried and tested with PHC workers in rural areas of India for several years.

Furthermore, there is an increasing quantity of literature of this "demystifying" genre available in the Western world, a proportion of which would transpose with little difficulty to an economically much less advanced setting. Illingworth's short manual (110) and much of Mary Sheridan's illustrated work (111,112) on childhood developmental stages and early play would require little adaptation. The Kennedy Foundation's "Let's Play to Grow" (113), Bjerre's "Orientation and Mobility for Small Blind Children" (114), Cotton's "The Hand as a Guide to Learning" (115) concerning cerebral palsy, and some other Spastics Society publications, all use straightforward methods, profuse illustration, little and inexpensive equipment. Studies for the Governments of USA and Australia (116,117) between them review 30 books or sets of program material designed to give away professional rehabilitation skills to lay persons.

Appropriate information is lacking in the field of Hearing and Speech disorders, so it is not surprising that the WHO/CBR Manual is particularly defective in this field. A study of papers on teaching the deaf and speech-disordered in developing countries (118-121) reveals the colossal problems involved even for trained teachers. The diversity of mother tongue is a major problem, exacerbated by the tonal character of many Eastern languages (122).

Indeed, the problems are considerable even with the full resources of modern technology, in monoglot special education systems. The Warnock Report (123) refers to "concern about the limited levels of language and literacy achieved by many young people in school for the deaf" in the U.K. The international consultant Armin Löwe (who recalls teaching deaf children without the benefit of any hearing aids (124)) admits that the prelingually profoundly deaf child of normal intelligence, with a lot of expert help, reaches the language level of a 3½ year old hearing child by the age of 12 on average (125).

Given the additional problems faced by deaf persons in rural Asia (126), the outlook in village home-based education is poor. The field is further complicated by the continuing virulence of the Oral/Total Comm./Manual debate and by philosophical differences in the perceived goals of education for the deaf. An experienced and brilliant oral teacher of the deaf known to us, who taught for six years in India and Sri Lanka, is contemplating return to the U.K. to take a course in manual communication in order to systematise a Tamil sign language: still convinced of the merits of the oral approach, but realistic about the needs of the thousands of unschooled deaf children. The Oralist educator van Uden, who reports starting reading with deaf children at about 3¼/4 years of age (127) and who is regarded by Löwe as among the foremost special educators in Europe, is viewed practically as a charlatan by an Association of North American parents of deaf children (128) Löwe in fact lists 23 special factors by which van Uden gets his remarkable results (125), none of which occurs in villages of the Third World. Without entering further into the debate, it would seem that studies such as that conducted by NASEOH in Bombay (129) and Ghosh in Calcutta (26) and the A.I.I.S.H. in Mysore are more likely to produce relevant material for the rural deaf that studies and polemics issuing from Geneva, New York and Stockholm. The 'Human Horizons' series, contributing notably to public and family information in the disability field, has a useful book on the deaf child (130), which one of our key parents in the N.W.F.P. is contemplating translating.

Speech disorders are even less well served with public information than hearing problems, although they bulk large in public perception of disability in the Third World. There seems to have been a smaller input of expatriate experience and skill in this field (with some exceptions in the Peace Corps), possibly because of the language barrier: more than most types of therapy, speech therapy requires accurate and confident grasp of local languages. Recently there have been 5 trained expatriate speech therapists in Pakistan, all housewives, and only one has acquired sufficient language competence to practice her profession and thereby to begin to grasp how her skills might be multiplied. Another made

a report to the Government (131) in which it is pointed out that people with allied skills could benefit from a short 'crash course' in speech therapy. It is apparent from standard texts (132,133) that speech therapy shares some common ground with education of the deaf and the mentally retarded. In fact, one of the problems of developing general speech therapy services is that therapists tend to be posted in special schools, and to devote the greater part of their time to children whose speech disorder is secondary. Self therapy (134) and indigenous methods such as hypnotism to allay the stammerer's nervous reaction, make some contribution to the field, which is one of the least adequately studied. Other indigenous practices such as beating left-handed children for using the "wrong" hand, and snipping with kitchen scissors beneath the tongue of the speech disordered child to "loosen the tongue-tie" are traumatic and disabling.

The considerable quantity outlined above of detailed public rehabilitation information written from field experience is merely that which has found its way to a backward Province of Pakistan. It is reasonable to suppose that a great deal more is being used and prepared around the world. The question may be raised, therefore, as to the place and future of the WHO/CBR Manual. Will it serve as a 'general introduction' to the field of rehabilitation? Professor Serpell (53) finds that it is already too complicated for his front-line workers, while his colleagues point out that it does not contain nearly enough detail. Yet again, as presented, the Manual is too bulky, and its style is criticised as being top-down and confusing (14).

Factors of size, sophistication and style really depend on the intended target. For the family with, for example, a blind child and with the desire to do something, the 60 pages of Fichtner's manual will not be too long, whereas the WHO training package for a blind child is far too short. The contents of the remaining 98% of the WHO Manual are of no concern to the individual family. Furthermore, their motivation to grasp the information will be higher than that of a PHC worker or community volunteer, and they start off by knowing their own child. Similarly, the teacher in a local rehabilitation centre, whose professional standing is involved, will cope with more sophisticated material. While I was writing this section, Mrs. Miles paid a visit to a family who had come for counselling 3 months back with their 12-year-old severely retarded daughter, Firzana. At the time, Firzana had never fed or toileted herself, never spoken or dressed herself, and had minimal eye contact. The father and mother, a clerk and a housewife, were given an hour's discussion and four short but detailed, illustrated pamphlets in Urdu, translations of materials from the Caribbean Institute of Mental Retardation, on toileting, feeding, speech

and dressing. After three months without follow-up or reinforcement, the family proudly showed Firzana feeding and toileting herself adequately, using the names of family members, and maintaining eye contact. Apart from pulling down pants for toilet, Firzana does not yet dress herself, but the family has gained vital confidence in her ability to learn. They are delighted, and wish only that they had discovered the pamphlets ten years ago.

It seems likely that there are three alternatives for the WHO Manual: either it receives a radical overhaul, starting again from scratch and rethinking the whole approach in the light of manuals such as those mentioned above and Werner's "Helping Health Workers Learn" (135); or it continues to be tinkered with as an introductory text, while the WHO develops or borrows a series of much more detailed disability-specific manuals; or it will be made redundant within another 3/5 years by the wider availability of other publications. It would be a pity if the WHO's distribution network and influence were not utilised for promoting technically sound, appropriate, detailed information material.

The other aspect of this section B(i), information for local inservice staff training, has been touched upon in some of the above comments. In the last few years there has been a commendable upswing of interest in providing skills to front-line workers, for example in the Manpower Model promoted by the late Allan Roeher (136) and in the agenda set for the mental handicap world by Peter Mittler (137). The importance needs to be emphasized of training methods that will build an appropriate level of confidence and reasoning power. In rehabilitation practice, progress may be much slower to appear than in PHC, especially if there is a large backlog of psychological trauma to be overcome. The rehabilitation worker needs more patience, more confidence and more adaptable thinking if he is to achieve positive results. This cannot be gained by following a series of instructions, though a framework of suggestions and leading questions may be appropriate. Interestingly enough, this is the conclusion of a Chinese booklet about a "barefoot therapist" (138): the hero attributes his success to thinking deeply about rehabilitation problems; and the booklet ends with him being faced by a problem to which he does not yet see the solution, and with reflections about the vastness of knowledge waiting to be discovered.

In Peshawar we began to feel that we might be achieving something when after 2½ years my wife succeeded in getting one of her teachers to disagree with her and to propose a different approach with one of the pupils. Two years later, another member of staff listened to some foreign "experts" describing their scheme for integrated education of

deaf children in Peshawar, and calmly told them why it would not work. Neither the "experts" nor the big shots accompanying them from Islamabad could counter his reasoned arguments. The scheme, which went ahead anyway, is duly foundering for the reasons predicted. Another year passed before the same teacher gained the confidence to leave us and set up his own school. One day, he or another will come to me and propose some better ways of developing rehabilitation facilities in the Province.

For sections B(ii) to (v), little appropriate information is available in format designed for assimilation by the target groups in Third World communities. Experience is beginning to build up in the Third World of integrating disabled children in ordinary classrooms (20), and there is a plethora of advice from the West, much of it mutually contradictory. There is little doubt that the local school increasingly takes over the community role of socializing the rising generation and transmitting the customs and traditions of each nation (which may not be identical with those of the local community). It could therefore be a key to integration of a future adult generation. Absence of disabled children from school would by contrast teach a "hidden curriculum" of separation and stigma. On the other hand, the overcrowded and under-planned schools across Asia are plagued by the failure of many non-disabled children to learn anything, and by high rates of drop-out and repeats (139), which holds little promise for children with sensory or learning impairments.

For attitude change in the public at large, very little work has been done in developing countries. Our own study (6) indicated that the official target of IYDP (1981) 'Full participation and integration' was widely inappropriate for the bulk of the public, whose perception of disabled people was dominated by fear and pity. This is quite possibly also true of supposedly more advanced nations. Attitude surveys are almost always carried out by self-report, and the Western public is sufficiently survey-sophisticated and self-conscious as to avoid openly avowing the negative reactions which people on the receiving end report as widespread. Attitudes seem to evolve through a number of stages. People do not take a single stride from "fear" to "action on behalf of", or from "pity" to "equal esteem". The field of public propaganda is crucial to the success of many developmental welfare programs, whether infant nutrition, sanitation, child health, women's status, in addition to rehabilitation. The guidelines (140) produced by a U.N. seminar in 1982 are good as far as they go, but need to be amplified by studies of their practical application, particularly in developing countries.

Materials for short training and reinforcement courses for front-line workers, whether local supervisors or Centre staff, are in short supply, but there is little doubt that this form of regular support is essential to the success of community centred rehabilitation. Mittler (141) emphasises this in the context of the U.K. Portage Project workers spending one day per week meeting together for discussion and problem-solving. Farrell (142) reviews and evaluates a nationwide effort in the U.K. to impart specific skills to staff working with handicapped children, and to measure the impact after a lapse of time on their practical handling of children. He concludes that the effort has been effective for those staff with higher starting skills, but less so for those with lower initial training, who may have found the course materials too difficult. The review indicates some of the complexities of assessing course usefulness, and the tendency at every stage for people to believe that what was done was good, without any factual evidence. An interesting experiment took place at a skills workshop in Hong Kong (101) where teams from 12 Asian countries took part, comprising carefully selected people of varied background, professional level and personal capacity who were all directly concerned with mentally handicapped people. The methods of instruction varied from lecture to domonstration, role play and group discussion, but throughout there was a strong emphasis on participation and sharing experience; a further emphasis was on formulation of concrete plans to be implemented by each country team working cooperatively on their return home. There were perhaps too many novel factors at work for there to be adequate analytical evaluation of this experience, but the independent evaluator appointed is still following up the outworking of the team goal plans two years later (143), which is one indicator of lasting effectiveness of the workshop.

It is probably true to say that Third World training methods generally major in 'hot', linear media such as print and lectures, which are memorised and half digested by the recipients. Audio visual aids have not yet made adequate inroads into this highly inefficient system. Again, there is not a great deal of appropriate visual material available for use in the Third World, and what has been produced is not widely known. In 1981 UNESCO produced a useful set of slides and multilingual text on modern special education in developing countries, with an emphasis on integration, in collaboration with the I.L.S.P.M.H., Christoffel Blindenmission and the Spastics Society of India. A great deal more of this type of material is needed, particularly showing a mixture of Western and Third World children engaged in similar types of activity: it is usually difficult to convince families in Pakistan that the method (and much of the equipment) we use here is no different * that used in the technologically advanced nations. We have used a

certain number of English filmstrips and slide sets in staff training in Peshawar; it is difficult to eliminate distracting factors, such as the elegant homes and glossy classrooms and mothers wearing short skirts, which convey a hidden curriculum of foreignness and high technology. An organisation is required that will do for rehabilitation what Teaching Aids at Low Cost (TALC) has done for medical education.

Information on technical aids appropriate for community based rehabilitation is currently the subject of a Newsletter by AHRTAG, a major project by Partners of the Americas, a Handbook in the Asia/Pacific region of Rehabilitation International, a number of other American projects and some publications by Mr. Donald Caston, listed by AHRTAG. The Appropriate Technology for Health directory (WHO) also lists several Indian organisations engaged in research and development of "appropriate" aids. Organisations such as the International Committee of the Red Cross and the UNHCR have lengthy experience in this field, through patching up war wounded persons and refugees in unpromising circumstances. The field appears to be more accessible to Western assistance or interference, since every handyman in Birmingham, Detroit or the backwoods of Provence can knock together a few sticks in his backyard, or attach bicycle wheels to a bucket seat in his garage, and believe that he has found the answer to the problem of inexpensive mobility for disabled Nepalese. Some of these gadgets may be good, but they tend to appear alien if they ever reach Nepal, they carry an unwelcome 'unsophisticated' image and they lack a production, distribution and marketing plan. Far more attention needs to be given to the latter, which will introduce the potential clients into the picture more realistically than seems to be the case in the present 'appropriate aids' field.

C) Network Coordination

Information potentially covering the main aspects of the lives of up to 300 million disabled people worldwide would require extensive stores and networks to handle, distribute, and make widely accessible. The Third World has hardly begun to hook into existing stores and networks, but must do so if rehabilitation is to develop speedily and optimally. Present international networks run with several parameters: the U.N. system (principally UNCSDHA, WHO, ILO, UNESCO, UNHCR and FAO); the Council of World Organisations Interested in the Handicapped (CWOIH); the Commonwealth (Royal Commonwealth Society for the Blind, Commonwealth Society for the Deaf, Commonwealth Association for the Mentally Retarded and Developmentally Delayed); disability-specific networks (e.g. I.L.S.P.M.H., World Federation of the Deaf, FIMITIC); those specific to professions (e.g. European Association of Special Educators, World Federation of Occupational Therapists); to consumers (e.g. D.P.I., World Veterans Federation); to donor constituency (e.g. Christoffel Blindenmission, International

Catholic Children's Bureau); to religions/philosophies (e.g. Camphill, Federation of L'Arche); to technology (e.g. AHRTAG, A.T.H.); to geographical area (e.g. Partners of the Americas; Nordic Disability Alliance; Asian Federation for the Mentally Retarded); to research (e.g. IASSMD, I.S.P.O.); to particular types of service provision (e.g. Cheshire Foundation, Goodwill Industries); and others created by regional institutes.

A number of efforts are being made to coordinate networks, against a certain weight of inertia, turf jealousy and mutually incompatible computer systems. The UNCSDHA, Vienna, intends to coordinate on a broad front, as the UN organisation responsible for the Decade of the Disabled 1983-1992. It is of course limited to "official" information provided by Governments, other UN organisations and NGOs, and is not in a position publicly to evaluate information and programs. The ILO is producing the excellent BLINDOC awareness service, and regional directories of rehabilitation facilities, while the WHO directory of Alternative Technology for Health covers some organisations and individuals with a special rehabilitation interest. UNESCO has in the past collected and published data on various features of special education worldwide. Among NGOs, Rehabilitation International coordinates the C.W.O.I.H., in addition to its own worldwide membership and information network. The two arms of the Joint Commission on International Aspects of Mental Retardation between them coordinate a great deal of mental handicap work. But of necessity these and various other efforts at coordination tend to be a long way from grassroots, while the grassroots workers tend not to have time or incentive to communicate into the networks. Furthermore there are organisations like Christoffel Blindenmission with 700 projects involving all the main disabilities worldwide, working through indigenous Church outlets, which have formidable network potential yet which do not connect immediately with the other types of network. There are hundreds of more general aid and development agencies having a 1% stake in rehabilitation, and remaining largely ignorant of what is being done just around the corner.

Peter Mittler (137) underlines the maldistribution of information: those people having least front-line contact with disabled persons are saturated with reports, papers and recommendations far beyond their power to absorb let alone to digest or act upon, while those who are faced daily with practical problems directly involving disabled persons have also to face their own lack of information or access to it. The world-wide state of the art in a single part of the disability information field is described at 90 pages length by Barbara Duncan (144) in 1981, and the scope of that part has certainly doubled since then. Regional 'Institutes' are one vehicle for a better distribution and access (145),

but it is unlikely that they will be adequately staffed or funded in the countries with the greatest needs. In a technology-dominated field it will be difficult to maintain good consumer orientation and an outward-going momentum towards an unsophisticated, non-technical, non-professional public. In fund-raising terms, information is not sexy. But information is power, prestige and status; nowhere more so than in countries with a severe information shortage. In rather few countries is there any tradition of handing out information gladly to all enquirers, unless the information has some ulterior motive of political or sectarian persuasion.

Study needs to be carried out of the major rehabilitation needs of populations in the Third World, and optimal methods of supplying them and of accessing the international networks and transforming available data into appropriate form and language. The field might be of interest to some disabled city-dwellers with home access to modern information technology, i.e. a telephone with modem, micro-computer, printer and photocopier, working in a semi-voluntary capacity. Scanning the flood of Western rehabilitation literature and reports for the less-than-1% that says something fresh and useful to the developing world is tedious and time-consuming. It requires a high level of interest in the reader. I can just about imagine a disabled Londoner living on his state allowance, with access to the flood and to expatriate Pakistanis as consultants, desiring to take on this research. In Islamabad I see a group of educated disabled persons (the education means they are from well-to-do families who will support them financially) exchanging ideas and needs with the London connection, and adapting/translating some of what comes through the post or over the wire into their micro, then pushing out the result to community centres such as we are mobilising, and getting feedback and more requests. The exchange of ideas already takes place on a modest scale. The Hesperian Foundation's latest Manual (105), assembled in the mountains of Mexico, includes ideas from refugee camps in Thailand, community schemes in Jamaica, Pakistan, Bangladesh and a dozen other sites around the world.

D) Balanced Planning and Evaluation Criteria

From the preceding discussion it is clear that a variety of approaches should be offered to countries and local communities at different developmental stages and different social and population structures. Criteria need to be developed to assist planners at various levels to understand the options and make informed choices. Sensible criteria can be developed only if there is a realistic evaluation of existing CBR schemes of all types, and for such an evaluation again a set of criteria and standards needs to be evolved which will hold in balance the cost, affordability, benefit to the individual, benefit to the community,

replicability or 'inspiration' factor. (I include the latter after friendly debate with David Werner, who inclines towards inspiring others rather than to making replicable models. As previous indicated, I believe that several replicable strategies should be offered, which will provide a framework within which inspiration, love and idealism can find greater fulfilment). Some 20 years experience of both PHC schemes and CBR efforts is available to suggest the guidelines. The Disabled Persons' Unit, UNCSDHA Vienna Centre, is currently revising a draft manual that goes some way towards meeting this need for criteria and guidelines.

I have discussed elsewhere (146) the problems faced by Western rehabilitation advisers trying to devise rehabilitation systems for Asian countries at very different stages of development. It is interesting to note that many similar problems are present in Latin America (147). Rehabilitation skills and philosophy need to be learnt or re-learnt in situ, according with the environment. However skilled and experienced the expatriate or Western-trained nationals, they will achieve nothing lasting until that have relearned their profession in the new context; not until doing so will they be in a position to impart their skills and knowledge. And this assumes a willingness and intention to share. Finding the right, well-motivated people to go away for training or to bring skills to a developing country is not easy. Perhaps the experience of modern missionary societies has some relevance: mission partners are increasingly being chosen and sent from a community to a community, rather than going as individuals to create their own work or to gain qualifications to further their own career. The sending community, at whichever end, chooses a person known to have appropriate character as well as skills to share or training need; the receiving community has the responsibility to welcome the whole person rather than simply exploiting the skill or imparting training.

Community-to-community partnership is not an easy answer: on the face of it there seem to be greater difficulties in trying to share resources between two communities than between a community and an individual. Yet in the long run communities have so much greater a range of resources, persons and expressions that when the partnership is consolidated it can become a very strong and lasting multi-channel link. That has been the experience of many Churches and congregations over the past thirty years, of the "Town-twinning" movement over a longer period, and of the International League of Societies for Persons with Mental Handicap, "Partnerships" scheme in the past five years.

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9.0 REVIEW COMMENTS

The following comments were received in the course of personal letters from colleagues in various countries, in response to the first draft of Where There Is No Rehab Plan. I extracted pertinent comments and returned them to each author with the request that I might publish them, which was granted in the case of those following. Each person is writing in a personal and private capacity, not as a representative of any institution or organisation.

I have not suppressed any critical comment received. The principal criticism of the first draft was that I was too hard on the WHO scheme. In the present edition I have modified some of my criticisms, and tried to show that the WHO scheme in its present form could answer some needs, and in a modified form could answer many needs. Approximately one third of the paper comprises suggestions for the future : I hope that it may count as reasonably constructive criticism.

M.J. Thorburn (Jamaica/Caribbean)

"It is clear from "Where There Is No Rehab Plan" that you have been able to collect a very great (and perhaps unique) variety of appropriate technology information from the Third World. I agree with your comments on the dissemination of information and liked the idea of the way in which the 1% of relevant information could be filtered out and channelled.

Your descriptions of Pakistan made me realise once again that one has to apply approaches successful in one area with great caution in others. The geographic and demographic characteristics of our mountainous islands are so very different. When you mentioned in earlier papers "small towns", I envisaged our small towns of 5-10,000 people, rather than yours of 30-50,000 !

I agree with you in so many details - most of them - but the general tone seems excessively critical of the WHO. I still think the WHO manual is a major breakthrough even though we are not using the WHO scheme or all of the materials. It opened some new doors for me and also vindicated what I have been trying to do in developing home-based early intervention programmes over the past ten years. I do not think you do justice to the fact that they (WHO) say quite clearly that the manual can be used to generate ideas and be adapted for local use.

The content of your document was fantastic - it is a very valuable piece of work, but overly biassed in one direction. I believe it could be a tremendous contribution if it were re-orientated as a positive compilation of alternative CBR strategies.

Ann Darnbrough (London, U.K.) :

I think it is very valuable to hold the WHO documents up to such close scrutiny, most particularly because it may help them from being enshrined in tablets of stone, when, as you say, over and over again, flexibility is what is required. I suppose in pulling away from institutional care, a move which was so desperately needed, the pendulum can inevitably swing too far. The answer does seem to be, as you suggest, a critical appraisal of the different types of institutional care. Home based care can be very isolating and demoralising.

I was very interested to read your comments on information representing power. It also represents privilege. Conversely, lack of information represents lack of privilege, powerlessness and added disability. In my experience, information is rarely handed out gladly to the poorer more underprivileged sectors of the community. Virtually the only places where this happens in the UK is through the Disability Information Advice Lines, which are all run by disabled people themselves.

Rafiq Jaffer (Lahore, Pakistan) :

To my mind no evaluation of the WHO CBR scheme to date comes anywhere near your own in terms of comprehensiveness, the variety of sources quoted, and the convincing, almost invincible logic of your arguments. In short, a devastating piece of work

which, to use your own phrase, knocks everything else out of the market on the subject.

I hope, for the sake of the disabled children of the world, that the high-ups in the U.N. concerned with C.B.R. will take your criticism for what it is - an attempt to improve on existing strategy rather than a sectarian attempt to grind one's own axe. This of course requires the ability to admit and learn from one's mistakes - qualities which, unfortunately, have a diminishing correlation with the size of an institution. The alternative will be greater frustration, apathy, and anger among the general population as well as rehab workers, and a decrease in the already precarious credibility of UN organisations to do anything effectively for the wretched of the Third World.

David Werner (Mexico / USA)

Your paper "Where There Is No Rehab Plan" is I think an extremely important and useful document. I find myself stressing many of the same points, particularly the point you make about the importance of diversity of approach, in beginning at the community level by bringing together those persons most intimately concerned about disability - namely, the disabled themselves and their relatives. The examples you give of the organic growth of organisation and activity from the bottom up are particularly important in demonstrating an alternative to the top-down, centrally standardized approach. All in all, your paper throughout is packed with excellent, well-documented and realistic alternatives.

It's funny (and disturbing) how the WHO model penetrates and manipulates one's consciousness. As project PROJIMO has developed, we have always advocated that as much as possible be done in the home and through the family, in terms of the rehabilitation of the disabled child. Nevertheless, and with disturbing frequency, we have found families where home rehabilitation just didn't seem to work. Sometimes a family situation is extremely difficult, due to a combination of factors such as unemployment, extreme poverty, drunkenness, ingrained attitudes, etc. In many such cases, the PROJIMO team has kept children at the center for an extended period of time. We used to feel sort of guilty about this; now we are beginning to see that in any community there are bound to be some family situations which can be further disabling to a child in spite of the efforts of the community and rehab team. In some of these cases we have actually managed to replace, for a critical period, disabled children with other village families. All in all, however, we have more or

less stumbled onto the "neighbourhood center" approach which you promote so eloquently in your writings.

However, from the base of the neighbourhood center, run by a local disabled team, we still try to make the home and family the primary focus of support and rehabilitation activities for the disabled child. I have a feeling that you probably agree with this, and certainly the gist of your rehabilitation broadcasts for rural villages places the emphasis on what can be done by the family in the home. (I realize that these broadcasts are mostly directed towards areas where there are still no community or neighbourhood centers.) However, in your "Where There Is No" paper, I think at times you take an overly strong negative view of the possibilities within the home and family. I don't know how Pakistan corresponds with Mexico, but here, certainly for every one family where the obstacles to significant home-focused rehabilitation are prohibitive, there are at least half a dozen families that are not only willing but eager to assume responsibility in this area provided they can access adequate information and guidance.

In short, if there is one change that I would suggest in your paper, it is to stress the importance of an integration between the neighbourhood centre and the family focus in rehabilitation - rather than to make it look as if it needs to be a choice between one or the other. I agree with you that the neighbourhood center is probably essential, both for family back-up and for enhancing the multiplier effect to other neighbourhoods and communities. Essentially, I think you do make this point, but there are times when you get so carried away with your attack on the WHO approach, that one might mistakenly believe you are throwing the baby out with the bath water.

Virginia Hoel (Norway / Austria) :

I found it very thorough, and lucid. It was good that you documented and quoted all the work that has been done on community-centred rehabilitation - I think it's important to counteract any attempt to monopolize this field. I am all for your idea of working to establish more resource centres, and to avoid the totally family-based set-up as unnecessarily isolating (and probably quite depressing for all concerned). The section on cost considerations I also found good. I think it's important to recognise that different sources of funding are available for different types of scheme - and that one does not necessarily detract from the other.

Evelyn Sithole (Zimbabwe) :

Like any rural sector in Africa, Zimbabwe's rural folks spend three quarters of their time working in the fields and when they return home there are chores to carry out. This leaves very little time for implementing the Manual in that the mother would be the one involved because father is usually away, being employed in the cities, and the older children are at school and therefore cannot devote as much time to helping. Who is going to use the Manual ? Under these circumstances, if I were a parent with a disabled child, I would find it quite difficult to cope with the Manual, as I would feel tired and irritable, which would not help the child's progress.

Making the family use the Manual is like throwing the disabled member of the family back at them. They have lived with their disabled and they have no break. Families will accept the Manual; **using** it will be something else ! Some might try to implement the programme, but the majority will put it away for the next rehabilitation assistant or health worker's visit and politely agree to all the questions asked by them.

The idea of a centre, preferably a recreation centre or a building where disabled persons integrate with able-bodied people and those with the same problems, would be perfect. Rehabilitation assistants and health workers would then train the disabled in these surroundings. The family could visit and see what has been done and what they could do to help them at home. At the same time, there is no one with preconceived ideas of what the disabled member of the family **cannot** do. The disabled person has a better chance of proving himself. We are now talking of integration of the disabled into Society and changing Society's attitudes towards them. How can that be done if training is done at home ? What better way of integration than this Centre ?

Fr. Adam Gudalefsky (Nepal / USA/ Hong Kong) :

The WHO manual has been a "problem" from my first acquaintance with it (WHO Delhi meeting in 1980). It was heavily criticized at every meeting (Hong Kong - Toronto - Nairobi), but merrily it "went through". (Much akin to the training program UNICEF conducted here several years back. Costs were 250,000 dollars. I offered to conduct it all for 5,000 dollars in a less expensive setting, but

UNICEF said "it's a different jurisdiction", "we must spend the money", etc., another great leap forward that "went through".) I really have not seen the manual work in any place I travel to. But the process continues. I see the rough copies of still more "manuals" for training being assembled at high costs ("we have to spend the money"). I do agree totally with your observations and conclusions. I prefer picking away at the "grassroots" (as you do) - and maybe once day we could talk over the "communications centre" you once wrote about.

Don Westaway (S. India / Australia) :

Good solid constructive criticism of the 'Rehab giants' is very timely because lower level planners are beginning to become active and often take what WHO, RI and others say as gospel. There must be a million good ideas which could come from the new workers who have, as yet, not begun to think about the subject, but will do so when they become involved. The urgency of the matter arising from the population explosion is the point which I think many lower level workers have not grasped, and I keep pushing it. I suppose that if anybody has the wisdom to publish this report for you, they will unfortunately want the blunt but true observations removed."

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